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# PREFACE

TO

## THE SECOND EDITION

IN preparing the present edition new material has been added to the account of Ovarian Pregnancy, and Multiple Ectopic Pregnancy has been more fully dealt with ; also an account of Epispadias and Hypospadias has been included in the section on Malformations.

The relative value of the extended operation for Cancer of the Cervix has been dealt with on the lines of the statistics laid before the International Medical Congress in 1913.

Some changes in nomenclature have been made, and upon this point we wish to express our appreciation of the friendly criticisms passed upon the first edition. Thus " Internal and External Capsular Hæmorrhage " give place to " Internal and External Tubal Hæmorrhage," and " Medullary " cancer of the cervix to " Endocervical " cancer. " Chorionepithelioma " also becomes " Chorionic Carcinoma " in agreement with the recently adopted nomenclature of the Royal College of Surgeons. Five coloured plates and several illustrations in black and white have been added.

The operative section has been increased by the addition of operations for the cure of rectocele and epispadias, while the removal of Broad Ligament Cysts has been rewritten and freshly illustrated.

We are indebted to Mr. Rendle Short for an account of Blood-Transfusion which will be found in an Appendix.

We have again to express our thanks to our Artists Dr. Dupuy, Mr. Sewell, Mr. Thornton Shiells, and Mr. Ford.

THOMAS WATTS EDEN.  
CUTHBERT H. J. LOCKYER.



# PREFACE

TO

## THE FIRST EDITION

IN writing this book the object of the authors has been to set forth a comprehensive account of the special diseases of women, and to keep an even balance between the pathological and clinical aspects of the work. This balance, at all times difficult to maintain, is, we believe, reached more easily by collaboration between two writers than by the hand of one alone. While it should satisfy the requirements of medical students of all classes, we believe that it will also assist the practitioner to elucidate and to deal with his difficult gynæcological cases.

Thanks to the generosity of our Publishers we have been able to illustrate fully all important pathological conditions, both in their naked-eye and microscopical features. With very few exceptions these illustrations have been prepared from material in our own collections, and most of the originals are to be seen in the Lockyer Collection in the museum of the Charing Cross Hospital Medical School. Use has also been made of a certain number of the illustrations which appeared in a former work on "Gynæcology" written by the senior author.

Coloured plates have been freely used where the presentation of colour was necessary for clearness of teaching.

With regard to the pathology of Chronic Endometritis and the results of Chronic Ovarian Inflammation, certain new views are advanced which may encounter criticism. We are ourselves convinced of their accuracy, and we believe that, when accepted, they will simplify and elucidate subjects upon which considerable confusion had hitherto prevailed.

The scope of the work is somewhat wider than that usually allotted to Gynæcology. Thus Appendicitis is included in the section dealing with Pelvic Infections, for reasons which are set forth in the text and need not be repeated here. Again, the results of Obstetric

Infection are dealt with more fully than is usual, and in our opinion this is necessitated by the fact that such conditions so frequently come under the care of the gynæcologist. A practical knowledge of Obstetrics forms an essential part of the training of a gynæcologist on account of the numerous points at which they overlap, and there is no doubt that Gynæcology has suffered in the past from the incursions of those who are not qualified by training to understand its clinical problems aright.

The classification which we have adopted will, we believe, be found to be convenient clinically, and to promote clearness in teaching. Pathological classifications we rejected because they involve to a greater or less extent the disassociation of conditions which are in close clinical relation. We therefore decided to apply the old Surgical Classification and speak of General Gynæcology, Regional Gynæcology, and Operative Gynæcology. Under these main divisions anatomical subdivisions have been adopted as far as practicable. The first division includes Anatomy and Physiology, Methods of Examination, Prominent Symptoms, Disorders of Development and Function, and Pelvic Infections. We believe it is not inappropriate to speak of these subjects as comprising the *general* aspect of Gynæcology.

The Operative Section could not be made to embrace a full consideration of technical details without exceeding the space within which we desired to work. Operating cannot be learned from books, and we believe that the section will be a sufficient guide for those readers who are accustomed to the general routine of modern surgical work.

To Messrs. Macmillan the Authors tender their grateful thanks for generously allowing them to borrow from the 'New System of Gynæcology,' in advance of its appearance, a considerable number of illustrations including coloured plates.

THOMAS WATTS EDEN.  
CUTHBERT H. J. LOCKYER.

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# GYNÆCOLOGY

## PART I

### GENERAL GYNÆCOLOGY























































## PLATE II

The sections were stained by Van Gieson's method. The muscle appears yellow and the fibrous tissue red in colour. The elastin is not differentiated.

For the estimation of the amount of elastic tissue at the various stages of life, see numerous Plates in the section on Chronic Metritis, pages 428-431.

















































































































































































































of small doses of bromide combined with valerian or with a vegetable tonic, such as cinchona, is however often useful.

Hæmorrhage and discharges at or after the menopause must in all cases be regarded as indications of the possible occurrence of malignant disease, the most likely seat of the disease being the cervix or the body of the uterus. A careful and complete internal examination must in all cases be made without delay, for successful surgical intervention is possible only in the early stages. The necessity for submitting to such an examination must be explained to and urged upon the patient, who may, at first, be unwilling to allow it. In the great majority of cases a local cause will be found for irregular and protracted bleeding at the menopause, but sometimes, as has been already mentioned, this is not so. This matter will be again discussed in connection with the diagnosis of cancer of the uterus (p. 547).











































must, then, be taken with special precaution. A bottle and cork, and a catheter, should be boiled for ten minutes to sterilize them completely. Then, with clean hands, the labia are separated and the vestibule and introitus vaginæ carefully swabbed with an antiseptic solution such as 1-4000 biniodide of mercury. A swab soaked in this solution is then passed just within the vaginal canal. The catheter is then directed into the meatus and the urine received directly into the sterilized bottle, which is at once closed with the sterilized cork. This is finally secured and the whole sent to the laboratory.























































































































































































































































the abdomen without drainage, leaving the placenta to be absorbed. That the placenta can be thus absorbed is shown by its total disappearance in cases of lithopædion. If this method is adopted it is essential that no preliminary attempt to detach the placenta should be made, but it should be left with its attachments entirely undisturbed. The risks of infection by organisms which may enter it from the bowel are unavoidable, but a small number of cases have been treated with success in this way.





















































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## PLATE VII

SECTION THROUGH A CELLULITIC EXUDATION IN THE PELVIS (PARAMETRITIS). (Seven weeks after parturition.) Note the marked engorgement of the vessels and also the free hæmorrhage into the cellular tissues. The large artery (A) contains a thrombus (T). The inset shows an outline of the microscopic section.































































































































































































**PART II**  
**REGIONAL GYNÆCOLOGY**











































































































anterior vaginal wall. The protruded mucous membrane becomes partially or completely strangulated, and forms a swelling which may be as large as a walnut (*see* Fig. 189). Its colour is deep red or nearly black, according to the degree of strangulation which has occurred ; at the apex of the swelling a small aperture is to be seen through which urine slowly dribbles. This condition causes severe pain, dysuria, frequency or incontinence, and sometimes vesical tenesmus ; the congested mucosa bleeds a little, either spontaneously, or whenever urine is passed. The condition is distinguished from a dark-coloured new growth by the fact that the urethral canal passes through its centre, whereas when a growth is present the meatus urinarius is always eccentric, and, more often than not, lies above the swelling, as was the case in the adenocarcinoma illustrated in Figure 186.

The *treatment* of the acute form is to reduce it, if possible, under anæsthesia ; this may, however, be impracticable, and if reduced the prolapse sometimes recurs. Excision of the prolapsed portion of the mucous membrane must then be practised, as described on page 860.

























fistulæ are usually best dealt with by removal of the corresponding kidney, a careful cystoscopic examination being first made to determine which ureter has remained in communication with the bladder. Attempts to effect an anastomosis between the distal end of the divided ureter and bladder have seldom been successful as a mode of treatment for ureteric fistulæ.



















































































1

2

3

4























































































**PLATE XVII**

**PREGNANCY IN A FIBROMYOMATOUS UTERUS. The fibroid has undergone 'red degeneration.'**



























































































































































































## **PLATE XX**

**ENDOCERVICAL CANCER COMBINED WITH CANCER OF THE BODY.**  
The cervix is expanded by a crumbling necrotic growth which is continuous with a carcinomatous condition involving the greater part of the uterine walls. Necrotic particles of growth, green in colour, lay loose in the cavity of the uterus.





































































## PLATE XXI

**A.— UTERUS SHOWING CHORIONIS CARCINOMA (M. Handfield-Jones).  
Note the hæmorrhagic character of the growth and its confinement  
to the uterine body.**

**B. — PORTION OF LUNG SHOWING SECONDARY DEPOSITS OF CHORIONIS  
CARCINOMA (Cuthbert Lockyer). The hæmorrhagic character of  
the metastases is well seen.**



































fore in constant functional activity. It is possible that abnormal increases in intra-abdominal pressure may lead to compensatory hypertrophy of these muscles. On the other hand, injury to these structures or to the transverse fascial bands from overstretching, or from laceration in child-birth, will seriously impair their efficiency, causing them to yield before the forces of intra-abdominal pressure, and thus to allow the occurrence of prolapse.

### DISPLACEMENTS

The following displacements of the uterus may be met with :

- (a) Forward—anteversion, anteflexion.
- (b) Backward—retroversion, retroflexion.
- (c) Inversion—turning inside out.
- (d) Downward—prolapse.

The term displacement of the uterus is understood to include some departure from the normal *position* of the organ, and also in most cases an alteration in the *curve of its axis*.

The simplest form of displacement is that in which an alteration of position occurs without marked alteration in the uterine axis. Thus the uterus may be pushed bodily forwards against the pubes (*ante-position*) by some tumour or collection of encysted fluid in the pouch of Douglas (see Fig. 129, p. 227); a little straightening of the uterine axis may result, but the organ remains anteverted. Similarly the uterus may be pushed back into the sacral hollow (*retro-position*) (see Fig. 304) by a tumour in the utero-vesical pouch, or may be drawn there by contraction of old inflammatory adhesions in the pouch of Douglas. Or it may be pushed over to one side of the pelvis by a laterally situated swelling, *e.g.* a cyst developing between the layers of the broad ligament on the opposite side (*sinistro-* or *dextro-position*—see Fig. 444, p. 777) or drawn over by contraction of the cellular tissue upon the same side. Again, the uterus may be raised above the level of the pelvic brim (*elevation*) by a collection of retained menstrual fluid in the vagina (see Fig. 97, p. 176), or may sink below its normal level, either from failure of its proper supports, or from increase of intra-abdominal pressure above it, produced by abdominal tumours or collections of fluid. Occasionally the uterus undergoes *rotation* on its long axis as is sometimes seen in connection with fibroid tumours (see Fig. 216, p. 438).

It will be obvious that such displacements as these, though of anatomical interest, in reality are only mechanical results of other morbid conditions which are of far greater importance, and are only capable of correction by removal of these conditions. With one exception it is doubtful whether they are of any practical importance whatever unless the displaced uterus becomes gravid. when, of course, the

























































































































































































































































































































































































## **PLATE XXIV**

**LIPOMA OF THE BROAD LIGAMENT.** The lipoma occupies the folds of the mesosalpinx with the Fallopian tube stretched over it. The fatty lobules lie upon a teratomatous cyst of the ovary.





**PART III**  
**OPERATIVE GYNÆCOLOGY**

























## GENERAL CONDUCT OF THE OPERATION

*Position.* For all operations on the pelvic organs, the inclined, or Trendelenberg position is of great assistance (see Fig. 420) ; it allows of the intestines being withdrawn from the operation-area, and kept out of the way ; and further, by raising the pelvis, it brings the contents of this cavity into easier reach. In the case of stout persons it somewhat embarrasses the action of the diaphragm, and so impedes aeration of the blood, with the result that marked cyanosis supervenes, but this condition when carefully watched is not of serious moment.

The *incision* which is most generally useful is the median, or paramedian, supra-pubic incision ; this gives better access to the pelvic cavity than any other. The lower end should extend down to the pubic bone, due care being exercised in avoiding the bladder ; free access is thus given to the pelvic cavity than when the incision is placed higher up. Occasionally an incision through the linea semilunaris, or through the rectus muscle, will give more convenient access as when, for example, the right adnexa and the vermiform appendix are affected. The transverse incision of Pfannenstiel may be used when a comparatively small space is required, as in operations for ventral suspension of the uterus. This incision divides the integument and the anterior rectal sheath transversely about one and a half inches above the pubes ; the cutaneo-aponeurotic flaps are then retracted up and down, and the muscle and peritoneum are divided in the mesial plane (see Fig. 452, p. 790). The resulting skin-cicatrix is concealed by the pubic hair, and the fact that the different layers are divided in planes which cross at a right angle greatly reduces the risk of the subsequent formation of a hernia. If more room is required the transverse cutaneous incision may be made higher up, half-way between the pubes and umbilicus.

Short incisions are, as a rule, to be deprecated ; the object of the abdominal incision is to provide free and easy access to the operation-area. Insufficient room prevents a proper inspection of the area of disease, prolongs the operation, often requires the use of a needless amount of force, and makes it difficult to conduct the satisfactory examination of other organs which is often called for. A long incision is no more likely to become the seat of hernia than a short one, and the sole argument which can be urged in favour of the latter is the so-called 'cosmetic' advantage of the more inconspicuous scar.

*Exposure of the Operation-Area.* Operative manipulations are greatly assisted by providing free access to the parts ; this is in part provided for by a suitably placed incision of adequate length, in the case of abdominal operations. Great assistance can be further obtained by the use of suitable retractors which hold apart the edges of the

























cut away the cervical endometrium—this also is superfluous. When cervical flaps are brought into apposition by suture, the latter is left long and the volsella removed. The uterine vessels are next cut off by inserting a ligature behind the clamp in each case. These ligatures are cut short as soon as they are tied, and an encircling ligature is now passed through the lateral wall of the cervix and made to include the uterine artery, thus bracing the latter to the cervical wall. Subsequently, the round ligament clamp, and those on the tubes and ovarian ligaments, are replaced by ligatures, which are all left long for the time being. When all clamps are removed there remain three sets or pairs of long ligatures on either side of the pelvis. From above downwards they are those (1) on the tube and ovarian ligament; (2) on the round ligament; (3) on the corner of the cervical stump (see Fig. 430). One strand of each pair is now cut off, and of the remaining three each is united to the one lying next to it. Thus, the tubo-ovarian ligature is tied to that on the round ligament, and one of these to the ligature on the cervical stump. The tubo-ovarian ligature should be reinforced by a second transfixion-ligature if there is the slightest degree of tension.

When the ligatures on either side are thus united, the cervix is pulled up at its corners by all the lateral structures which have thus been brought together. The peritoneal edges are finally apposed over the cervical stump by a running suture from left to right (see Fig. 431). The wound must be absolutely dry at the finish. The mattresses and rubber-sheet are now removed, and the abdomen closed as already described on page 756.

Figure 432 gives a scheme of subtotal hysterectomy in a case where both appendages are to be removed.

## TOTAL ABDOMINAL HYSTERECTOMY : PANHYSTERECTOMY

In this operation the entire uterus is removed (with or without the appendages) by dividing the vagina close to its attachment to the cervix. It is definitely indicated in the surgical treatment of interstitial cervical fibroids (see Fig. 223, p. 446), where the cervix has been drawn up and expanded by the growth. It is the method of hysterectomy usually adopted when it is necessary to take the uterus away for cancer of the *body*, and in cases of double pyosalpinx. Many surgeons employ the *total* to the entire exclusion of the *subtotal* method of hysterectomy. The advocates of *total* hysterectomy claim that it is the better operation (1) because carcinoma rarely develops in the portion of cervix where it is left behind, over thousands of cases having been recorded (see p. 467); (2) hæmostasis is better secured in the total operation. On the other hand, the total operation takes longer to complete—therefore where speed is a consideration, as in Cæsarean hysterectomy, the *subtotal* method is the best procedure.













fundus of the bladder. The left uterine vessels are then cut between forceps and the cervix cut straight across from left to right until it hangs by the right broad ligament. The latter is secured with a pair of curved museaux, or with Moynihan's cholectomy forceps (see Fig. 438), whilst the uterus and tumour are rolled still further to the right and dragged up (see Fig. 437). The only attachments still to be divided are the right appendages. These are clamped and severed from below upwards.

(b) **Doyen's Panhysterectomy.** This is a modification of the classical method of performing total hysterectomy. After drawing the uterus well up and packing off the intestines, the tumour and uterus are held forwards to obtain a good view of the lower part of the post-

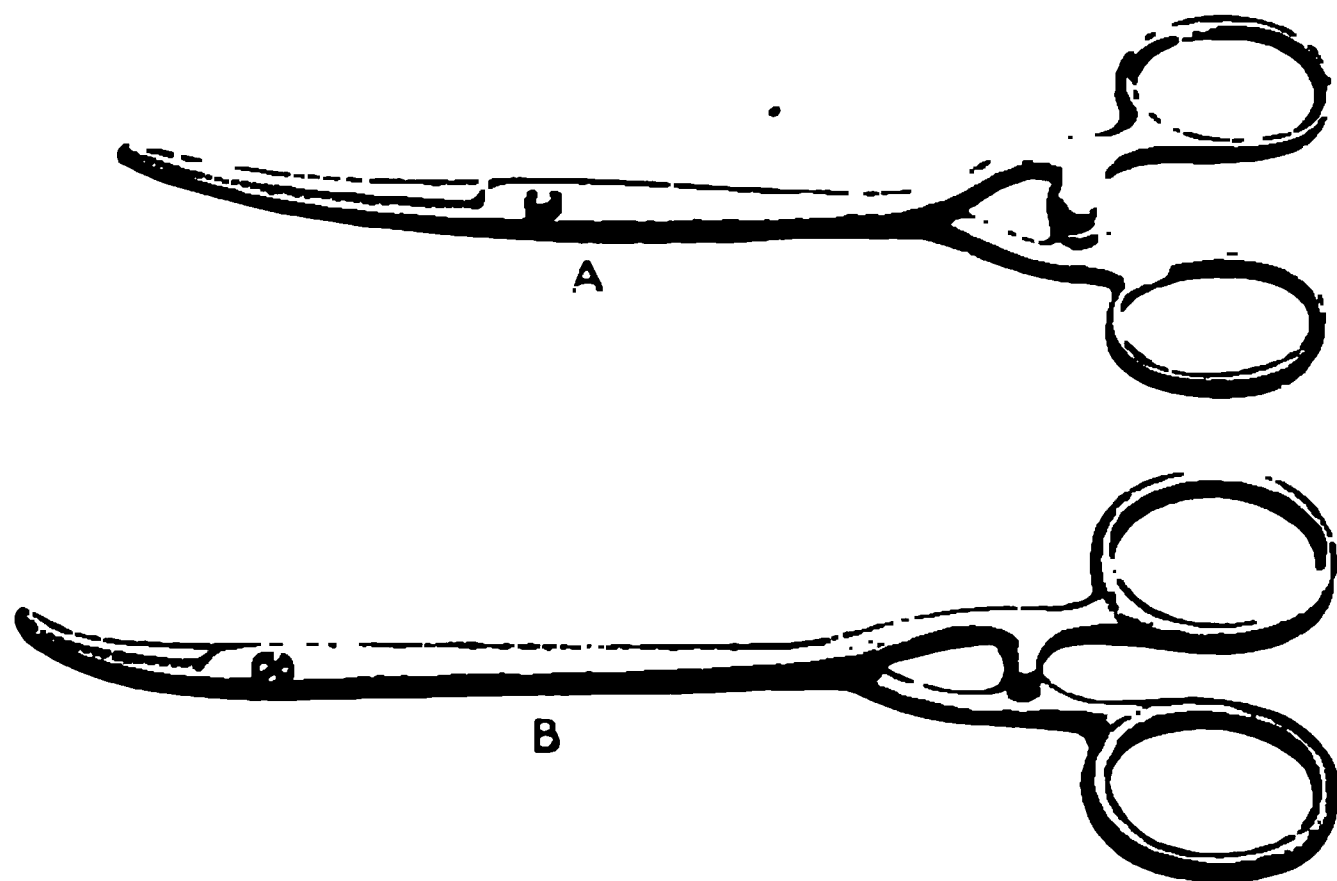


FIG. 438. A, Museaux forceps; B, Cholectomy forceps.

uterine wall. The *posterior vaginal fornix* is then opened, and the cervix is thus exposed from behind. With a stout volsella the cervix is drawn through the opening in the vagina, and its attachments to the vagina, laterally, and in front, are severed from below upwards. The utero-vesical pouch is divided, the uterine vessels are clamped and divided, and finally the appendages are treated likewise. The operation is carried out entirely from below upwards.

(c) **Pryor's Total Hysterectomy.** By this method the surgeon proceeds as is done in Kelly's continuous left-to-right subperitoneal hysterectomy, excepting that the lateral dissection is carried further down so as to allow the line of amputation to pass across the vagina instead of through the substance of the cervix (see Fig. 439). It is the most expeditious manner of performing panhysterectomy.

### The Radical Abdominal Operation for Carcinoma of the Cervix Wertheim's Operation

The principle upon which this operation is based consists in the removal of infected cellular tissue and glands, and also of *enough*



time Wertheim's operation has become the method of selection most of the competent gynæcologists in this country.

A point of great importance in estimating the relative values of extended abdominal and the extended vaginal operations is the *percentage operability*. There is no doubt whatever that a vast number of cases can be dealt with by the abdominal route which are beyond the reach of those who operate only *per vaginam*. De Ott bases his statistics on 345 vaginal hysterectomies performed during *twenty years*. Wertheim saw 405 cases of cervical cancer during *three years*, of these he was able to select 214 for the extended abdominal operation thus raising the percentage operability to 55·5. The upholders of the preference for the vaginal route do not state the number of patients from which they have selected their operation-cases, so that we are not able, from the latest statistics published at the International Congress in London, to state, in definite figures, the relative percentage operability of the two procedures, but in our opinion it would be reasonable to assess it as 4 to 1.

In estimating the *final value* of the extended abdominal operation a freedom from recurrence for *five years* was taken as the standard but Weibel's statistics (1913) show that recurrences occur to an extent of 7·7 *per cent.* between the period five to seven years after operation. He therefore claims that final results should be estimated upon a seven-years basis. For the moment there are only results estimated upon the five-years basis from which to draw conclusions. Of 450 radical operations performed by Wertheim 186 cases were free from recurrence after five years; this gives a percentage of 41·3 from recurrence. De Ott claims for the extended *vaginal* operation in Schauta's hands it yielded 37·9 and in his own 34·1 *per cent.* 'cures' after a period of five years. The relative value of the results by the abdominal and vaginal operations, can only be estimated by giving due consideration to the percentage operability. The method of Wertheim deserves pre-eminence from the fact that it enables the operator to deal with cases too advanced for the extended vaginal operation to be carried out.

**The Operation.** When the case is advanced the patient is kept in bed for a week or ten days in order to employ means of rendering the cervix and vagina as clean as possible, and also to improve the patient's health generally. With a sloughing growth accompanied by offensive discharge it is customary to apply the actual cautery under anæsthesia and to scrape away as much of the necrotic tissue as possible. This is followed by peroxide of hydrogen (10 vols.) douches, and by application of acetone and iodine to the raw surface. The wound on the cervix should be as clean as possible before the major procedure is undertaken. Immediately before the operation, the vagina is swabbed out with 2 *per cent.* iodine solution, and packed with sterile gauze, an end of which is left outside the vulva.



















































































































































































































































It is, of course, of prime importance to distinguish shock from hæmorrhage, and the following points of contrast must be borne in mind.

<i>Shock</i>	<i>Haemorrhage</i>
(1) Onset immediate.	Onset after an interval, it may be, of several hours.
(2) Patient lethargic, sleepy or stuporous.	Patient distressed, or restless and excited.
(3) No pain.	Abdominal pain, often severe.
(4) Pulse small, rapid, artery distinct.	Pulse small, rapid, artery flabby.
(5) Respiration shallow and quick.	Respiration deep and laboured.
(6) No attacks of syncope.	Recurrent attacks of syncope.

Shock may continue for many hours in spite of treatment, and sometimes all attempts at restoration fail and the patient dies. Usually, however, a gradual reaction sets in, the pallor diminishes, the surface of the body becomes warmer, the temperature rises, and the pulse becomes stronger and more rapid.

The *treatment* consists in endeavouring to restore the circulation by wrapping the patient in warm blankets, and maintaining heat with hot bottles which, however, must be very carefully shielded from contact with the skin. Burns of a serious nature may be caused during unconsciousness by comparatively low temperatures. In addition, a pint of warm saline should be administered *per rectum*, and the foot of the bed raised to a height of ten to twelve inches. Other means should be employed to raise blood-pressure, and for this purpose nothing is more effectual than pituitary extract, which should be given hypodermically in the doses previously stated (*see* p. 138). This may be repeated in four hours if necessary. Strychnine in full hypodermic doses ( $\frac{1}{30}$  gr.) is also freely given by some surgeons, although Crile, on theoretical grounds, advises against it. Its stimulant action on nerve-centres is probably of service.

In very severe cases reliance must be placed upon the subcutaneous or intravenous injection of saline solution; the former is the simpler method and suffices for all but the most urgent cases, for which the intravenous method should be reserved.

A convenient apparatus for subcutaneous transfusion is that shown in Figure 537, the whole of which may be readily sterilized by boiling. In the female, the best place for the injection is beneath the mamma or beneath the skin covering the ribs in the axilla; half a pint can be introduced on each side, and will be rapidly absorbed. The skin must be carefully sterilized before introducing the needle; air must be completely expelled from the tubing, and the whole procedure conducted with scrupulous antiseptic precautions. Extensive suppuration, or even sloughing of cellular tissue, may result from

























vaginal or vulval than in an abdominal wound. Not only is the vaginal wall more difficult to disinfect before operation, but also much more difficult to preserve from post-operative infection, owing to the proximity of the urethra and anus. Operations, such as curettage and dilatation of the cervix, which involve no cutting, require no special after-treatment, except a few days' rest in bed.

External wounds should be carefully and simply treated. After evacuation of the bowels or bladder the surfaces should be irrigated with a weak antiseptic solution, and a vaginal douche of similar kind should be given daily after the first forty-eight hours, a soft rubber tube being employed for the purpose. After all oozing from the incision has ceased, *i.e.* about forty-eight hours, the wounds may be covered with strips of lint spread over with a soft boric acid ointment. This serves to protect them to some extent from contamination.

In the opinion of many operators the catheter should be used every eight hours for the first four days, after which the patient may be allowed to pass water naturally in the sitting position or upon her hands and knees. An aperient should be given on the third morning. In the case of perineorrhaphy for complete rupture involving the anus the first action of the bowels requires careful management. The diet should be fluid only until this time has been passed, in order to limit the bulk of the contents of the bowel. Castor-oil is probably the best aperient to administer, and it may usefully be supplemented by giving a small enema of warm olive oil, which may be retained for a time and will serve to soften the rectal fæces. In this manner the first action is usually rendered easy and painless. Subsequently it is best to secure a daily action in order to avoid the formation of hard masses. Straining at stool is more liable than anything else to do harm in the case of a complete perineorrhaphy.









citrate solution with the blood. If clotting occurs in the needle (this does not occur unless there has been bungling) use the other needle. Collect twenty ounces of blood.

The writer has never seen the donor suffer in any way, but it is well after the blood-letting to keep him in bed for twenty-four hours. In America, professional donors give blood at intervals of a fortnight.

*The Transfusion.* Whilst there is no probability of the citrated blood spoiling for an hour or so, the transfusion should be proceeded with as quickly as possible. Prepare the arm, nick the skin, and insert the needle, but with the point directed towards the *shoulder* in this instance. The vein may be difficult to find; in which case it is necessary to dissect for it. Replace the aspirator pump by the pressure bulb, and see that blood is issuing from the needle as the latter is inserted, in order to avoid injecting air. If one needle is clean and the other soiled, use the clean one. Remove the bandage from the patient's upper arm, and by squeezing the rubber bulb (Fig. 538), force the blood into the vein. It takes about fifteen to twenty minutes to give a pint of citrated blood.

**Difficulties and Dangers.**—1. It may be difficult to obtain donors. The writer keeps volunteers, ready tested out, available at short notices, and pays them so much a time.

2. The citrate solution may form a precipitate on boiling. It will do so if prepared with tap water; distilled water should be used.

3. Blood may clot in the inlet needle or in the tube. This is caused by a dirty needle, or by faulty attempts to enter the donor's vein. Use the other needle, and *dissect* for the vein.

4. Blood may clot in the bottle. This is due to insufficient agitation; it is not likely to occur if the citrate solution is added in two instalments. A little clot at the bottom of the bottle does not matter.

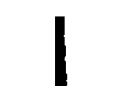
5. The blood may refuse to flow into the receiver's vein in spite of vigorous pumping. This may prove a real difficulty. A powerful pressure bulb, a large needle, and a wired-on rubber stopper all help. The causes of difficulty are the high viscosity of blood and the narrow needle, or active vein-spasm. The latter difficulty may be overcome by using the internal saphena vein (dissected out) in the groin. The writer keeps a 6-oz. all-metal syringe, with needle boiled, to use if all else fails, but this is seldom needed.

6. The patient, during the transfusion, may complain of tension in the chest and a bursting feeling. This is due to too-rapid transfusion. Wait a little, and 'pump' less vigorously.

7. After the transfusion there may be vomiting, a rigor, or a rise of temperature. These cannot be helped, and no harmful results therefrom have been noted.

8. There may be vomiting, dyspnoea, an urticarial rash, a quick weak pulse, convulsions, or coma during the transfusion; also hæmaturia or hæmoglobinuria may follow afterwards. These complications







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